CAP Mozambique

Strengthening Leading Mozambican NGOs and Networks II

Performance Monitoring Plan (PMP)

CAPABLE
PARTNERS PROGRAM
Mozambique

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Illustrative Performance Monitoring Plan (PMP)

The FHI 360 Performance Monitoring Plan (PMP) for the Strengthening Leading Mozambican NGOs and Networks project (CAP Mozambique) has four primary components:

- CAP Mozambique Development Hypothesis
- The narrative description of the results framework (1a) and PMP (1b).
- A graphic presentation of the results framework.
- The PMP matrix which covers indicators; definitions, data collection methods, responsibility, and frequency; data sources; and baselines/targets.

1. CAP Mozambique Development Hypothesis

The CAP Mozambique development hypothesis asserts that quality service delivery of HIV/AIDS treatment, care, and prevention activities is dependent upon civil society organizations' technical and institutional capacity, and that the provision of grant financing to these organizations must be accompanied by appropriate training and technical assistance. In order to implement quality activities, organizations must have adequate technical capacity in the given programmatic area they are targeting, but the effectiveness of these interventions depends on the commitment and leadership of the organizations' governance structures, its financial and administrative capacity, its relationships with stakeholders, and other elements which contribute to the organizations' overall institutional strength.

CAP's approach is to provide training and technical assistance in multiple areas to support holistic organizational growth, thereby increasing the effectiveness of programmatic interventions. The CAP approach does not depend on training as the key mechanism for improving institutional capacity, but rather using training as one of many tools to support organizations. Organizations that receive grants from CAP are provided with targeted technical assistance specifically linked to project performance, as well as broader assistance through the organizational development department that concentrates on each organization's overall institutional goals. With this dual approach, CAP is strengthening the quality of CAP-funded interventions as well as contributing to the sustainability of each organization.

2. Narrative Description of Results Framework and PMP

The purpose of the CAP Mozambique project is to scale up service delivery of HIV/AIDS treatment, care, and prevention activities by strengthening the technical capacity and institutional development of Mozambican non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), networks, and associations, thereby moving towards "Mozambicanizing" the response to the HIV/AIDS epidemic.

(a) Results Framework

The CAP Mozambique project will include a wide range of activities that contribute toward the overall program goal, as well as to the specific objectives, expected results, and outcomes as set forth in the request for proposals (RFP). The results of CAP Mozambique will be:

1. Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations increase capacity to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services;
2. Expanded HIV/AIDS prevention behaviors among most-at-risk groups through NGOs and partners programs;

3. Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections;
4. Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas;
5. Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families; and

In addition to the results described above, CAP Mozambique captures results linked to USAID Gender and Health results. These indicators are captured in the PMP matrix.

(b) Program Performance Management Plan (PMP)
The project will use a number of monitoring and evaluation tools and approaches specifically adapted for the program and the country context to effectively capture results. The following are a few examples:

1. Monitoring of Output/Outcome Indicators
CAP Mozambique will monitor output and outcome indicator progress on a quarterly basis. Grantees will be trained on data collection for indicators specific to their projects at the initiation of grant activities and will report on these to FHI 360.

2. Baseline Survey
CAP Mozambique conducted a baseline survey to support the design and development of project activities, as well as provide the project with key baseline data for evaluation purposes. The baseline survey focused on measuring the outcome of the activities implemented by CAP Mozambique grant recipients within their target communities. The baseline focused on measuring the outcome of CAP Mozambique's prevention work in its target provinces. An endline survey will be conducted to measure change on these key interventions.

Capacity-Building Assessment Tools

CAP Mozambique will conduct a number of assessments to measure the increased technical and institutional capacity of its grant recipients and other organizations targeted with capacity-building support.

a) **Organizational Development Assessment** – Baseline and follow-up participatory self-assessments will be facilitated with each participating organization to assess improvement in institutional capacity.

b) **CSO Project Development Assessment** – This tool measures the capacity of civil society organizations (CSOs) to design sound HIV/AIDS prevention, OVC, and/or HBC projects. It assesses a range of skills, from analysis of the problem to overall project design. It can be used to compare project proposals and/or workplan submissions from CSOs for funding.

c) **CSO Budget Development Assessment** – This tool measures the capacity of the CSOs to develop realistic costs for their technical proposals and/or workplans.

d) **Health Check** – This questionnaire is conducted with potential grant recipients early in their award to assess the organizations' capacity to effectively manage grant funds, focusing on financial systems. FHI 360 will facilitate the Health Check in the early months of each CAP Mozambique grant's award, and compare the results to gauge organizational improvement in systems.

e) **OVC Care Assessment** – This tool measures the capacity of CAP grant recipients to deliver quality OVC care. A baseline and follow-up assessment will be conducted to measure change in this technical capacity for grant recipients.

f) **Prevention Programming Assessment** – This tool measures the capacity of CAP Mozambique grant recipients to develop and deliver effective HIV/AIDS behavior change programming. A baseline and follow-up assessment will be conducted to measure change in this technical capacity for grant recipients.

g) **CSO Reporting Assessment** – This tool measures the capacity of the CSOs to report accurately and holistically on their quarterly activities and results.

h) Subgrant Management Capacity Assessment – This assessment will be conducted with CAP Mozambique grant recipients that manage subgrants, and will capture their capacity to solicit, select, award, manage, and monitor these subgrants.

3. Focus Groups

Focus groups are conducted to support the design of CAP Mozambique grant recipient interventions, as well as are used as qualitative data to support quantitative data collection. Focus groups will be facilitated with recipients of CAP Mozambique training and technical assistance (TA), CSO representatives, members of CAP Mozambique grantee target communities, and others.

Strengthening Leading Mozambican NGOs and Networks (CAP Mozambique)
Results Framework

AO: Scale up service delivery of HIV/AIDS treatment, care, and prevention activities by strengthening the technical capacity and institutional development of Mozambican non-governmental organizations (NGOs), community-based organizations (CBOs), faith-based organizations (FBOs), networks, and associations.

IR1: Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations increase capacity to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services.

- Number of Civil Society Organizations using USG assistance to improve internal organizational capacity
- Number of Mozambican civil society organizations using USG assistance to contribute to the health system
- Dollar value of program funds obligated to local organizations
- Number of up-and-coming organizations that graduate to advanced
- Number of advanced organizations that are recommended for USAID funding
- Number of individuals trained in institutional capacity building
- Number of organizations demonstrating increased capacity in 2 or more areas
- Number of meetings facilitated to share experiences and lessons learned with CBOs/FBOs/NGOs
- Number of indicators assessed by a data quality audit

IR2: Expanded HIV/AIDS prevention behaviors among most-at-risk groups through NGOs and partners programs.

- Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards
- Number of community health and para-social workers who successfully completed a pre-service training program
- Number of individuals trained in institutional capacity building
- Number of targeted condom service outlets
- Number of mass media spots delivered
- Increased number of individuals who have sought counseling and testing
- Percentage of individuals reporting increased dialogue about high-risk behaviors
- Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
- Increased number of individuals reporting consistent use of condoms

IR3: Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections.

- Number of intended target population reached with individual and/or small group level interventions that based on evidence and/or meet the minimum standards
- Number of intended target population reached with individual- and/or small group- level interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards
- Number of community health and para-social workers who successfully completed a pre-service training program
- Number of people referred to health services by community-based organizations
- Number of individuals trained in institutional capacity building
- Increased number of individuals reporting reduction of engagement risk behaviors associated with HIV
- Increased number of individuals who have sought counseling and testing
- Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
- Percentage of individuals reporting increased dialogue about high-risk behaviors
- Percentage of individuals reporting increased dialogue about social norms that influence high-risk behaviors

IR4: Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas

- Number of OVC receiving OVC services
- Number of community health and para-social workers who successfully completed a pre-service training program
- Number of individuals trained in institutional capacity building
- Number of people referred to health services by community-based organizations

IR5: Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families.

Additional Indicators

- Increased male involvement in seeking health services
- Number of individuals reached through USG-funded community health activities
- Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)
- Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.

Performance Monitoring Plan

Result 1: Increased capacity of Mozambican CBOs, FBOs, NGOs, networks, and associations to develop and manage effective programs that improve the quality and coverage of HIV/AIDS prevention, treatment, and care services.			
Performance Indicator	**Indicator Definition**	**Data Collection a) Method, b) Responsibility, c) Frequency**	**Baseline/Target Values**
Number of Civil Society Organizations using USG assistance to improve internal organizational capacity	CSOs include labor unions. Improved capacity refers to, inter alia: establishing transparent and accountable financial systems, establishing internal democratic mechanisms, and establishing better ability to represent constituent's interests. CAP CSOs counted under this indicator include those participating in financial management training, Intercambios, exchange visits, grant recipients and subgrant recipients under umbrella awards that receive institutional capacity building.	a) Project Records b) FHI 360 c) Quarterly	Y1: 69 Y2: 76 Y3: 86 Y4: 91 Y5: 70 Baseline Value: 0
Number of Mozambican civil society organizations using USG assistance to contribute to the health system	Civil society organizations include community-based organizations, labor unions, NGOs, associations, networks, and umbrella organizations. A contribution to the health system using USG assistance captures CSOs provided with funding through CAP Mozambique to improve the quality and coverage of prevention, treatment, and care services. This includes CAP grant recipients and subgrant recipients under umbrella awards (organizations providing grants, subcontracts, and transfer of goods).	a) Project Records b) FHI 360 c) Quarterly	Y1: 49 Y2: 56 Y3: 44 Y4: 72 Y5: 65 Baseline Value: 0
Dollar value of program funds obligated to local organizations	The dollar value of program funds obligated to local organizations refers to the amount CAP Mozambique has obligated to Mozambican organizations to implement their grants. A "local organization" must: • Be organized under the laws of the recipient country; • Have its principal place of business in the recipient country; • Be majority owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; and • Not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the recipient country. The term "controlled by" means a majority ownership or beneficiary interest as defined above , or the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment, or tenure of the organization's managers or a majority of the organization's governing body by any means, e.g., ownership, contract, or operation of law. "Foreign entity" means an organization that fails to meet any part of the "local organization" definition. Government controlled and government owned organizations in which the recipient government owns a majority interest or in which the majority of a governing body are government employees, are included in the above definition of local organization.	a) Project Records b) FHI 360 c) Semi-annually	Y1: N/A Y2: N/A Y3:N/A Y4: $7.7 million Y5: $4.6 million Baseline Value: 0

Number of up-and-coming organizations that graduate to advanced	Up-and-Coming organizations are those classified by CAP Mozambique to have the basic management and technical capacities in place to effectively manage a subgrant. Advanced organizations are those that meet CAP Mozambique's eligibility criteria to be advanced – which include a history of managing multi-year awards, clear separation of roles between the board of directors and implementing staff, and documented policies and procedures for financial management, procurement, human resources, travel, and inventory management.	a) Graduation process (desk review, site visit, internal evaluation meeting) b) FHI 360 c) Semi-annually	Y1: 0 Y2: 0 Y3: 0 Y4: 1 Y5: 2 Baseline Value: 0
Number of advanced organizations that are recommended for USAID funding	Advanced organizations are those that meet CAP Mozambique's eligibility criteria to be advanced – which include a history of managing multi-year awards, clear separation of roles between the board of directors and implementing staff, and documented policies and procedures for financial management, procurement, human resources, travel, and inventory management. Organizations are recommended to USAID for funding if they successfully pass CAP Mozambique's graduation process.	a) Graduation process (desk review, site visit, internal evaluation meeting) b) FHI 360 c) Semi-annually	Y1: 0 Y2: 0 Y3: 0 Y4: 1 Y5: 1 Baseline Value: 0
Number of individuals trained in institutional capacity building By individuals trained to promote HIV/AIDS prevention through behavior change By HIV palliative care By OVC Care By organizational capacity development By stigma/discrimination By policy development (advocacy) By project and budget development By child rights	Institutional capacity building is defined as training that supports an organization's capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills. The aggregate indicator includes all individuals trained in subcategories. An individual trained in multiple areas is counted for each training received. Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills, or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently. Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or "hands-on" training, such as mentoring or structured supervision, if the following three criteria are met: 1) Training objectives are clearly defined and documented; 2) Participation in training is documented (e.g. sign-in sheets or some other type of auditable training); and	a) Project Records b) FHI 360, Grantees c) Quarterly	Y1: 325 Y2: 487 Y3: 574 Y4: 1,047 Y5: 341 Baseline Value: 0

By individuals trained to provide training and technical assistance to support CSOs	3) Program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.). Training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones. **Training Areas:** • HIV/AIDS prevention through behavior change training will support CSOs to implement formative research to thoroughly analyze the situation and target audience, and develop and deliver appropriate messages and mediums to affect behavior change. • HIV palliative care training will support HBC caregivers to provide medical care or treatment that concentrates on reducing the severity of disease symptoms deriving from HIV/AIDS. • OVC care training will help OVC caregivers provide one or more of the following services and support to children, families, and their communities to ensure that orphans and vulnerable children grow and develop as valued members of their communities: psychological, spiritual, preventive, food support, shelter, protection, access to health care, education/vocational training, and economic strengthening. • Organizational capacity-development training will support CSOs to develop the capacities which enable them to function as a sustainable CSO, including governance, management, human resources, financial resources, external relations, and technical capacity. • Stigma/discrimination training is defined as training for health care professionals (including CSO and government health officials) on how to reduce their own behaviors that may lead to stigma and discrimination against people living with HIV/AIDS and to challenge others in examining and rebuking behaviors that create or support stigma or discrimination. • Policy development (advocacy) training is defined as a) policy analysis and research, b) policy dialogue and advocacy, c) policy development, and d) monitoring of policy implementation. Policy areas of greatest interest to PEPFAR goals include: human resources for health, gender, OVC, counseling and testing, access to high-quality, low-cost medications, stigma and discrimination, strengthening a multi-sectoral response and linkages with other health and development programs, pain management for PLWHA, post exposure prophylaxis, and laboratory accreditation. • Project and budget development training will support CSOs to a) generate a project design through a proposal and/or workplan and b) develop a realistic budget to support project implementation. • Child rights training is defined as training for health care professionals (including CSO and government health officials) to understand child rights, recognize violations of child rights, know how to respond to these situations when they occur, and know how to prevent violations of child rights. Individuals trained to provide training and technical assistance to support CSOs are defined as recipients of CAP Mozambique training that intend to provide TA or training in organizational or technical skills to other CBOs/FBOs/NGOs.		
Number of organizations demonstrating increased capacity in 2 or more areas	Capacity is defined as the skills, approaches, and resources drawn upon to implement project activities. The aggregate indicator includes all organizations demonstrating improvement in 2 or more subcategories.	a) Capacity-Building Assessment Tools	Y1: 31 Y2: 40 Y3: 24 Y4: 8 Y5: 8
By improvement in organizational development areas (by self-assessment)	Organizational development includes: governance, management, human resources, financial resources, external relations, and technical capacity. Baseline and follow-up ratings in each organizational development area are reached through a process of self-assessment.	b) FHI 360	
By improvement in project development capacity	Project development capacity is defined as the ability to a) demonstrate a solid analysis of the problem, b) define	c) Quarterly	

By improvement in budget development capacity	the target audience, c) include the target audience in the analysis as appropriate, d) demonstrate a sound strategy for implementation, e) apply appropriate methodologies (generally accepted practices in behavior change communication (BCC) for prevention or quality OVC care, for example), and f) allocate sufficient resources to implement the project.		Baseline Value: 0
By improvement in financial management capacity			
By improvement in quality of OVC care	Budget development capacity is defined as the ability to develop a budget that is realistic, provides adequate resources to effectively implement program activities, includes costs that are allocable, reasonable, and allowable, and provides adequate details to describe each cost.		
By improvement in quality of prevention programming			
By improvement in reporting	Financial management capacity is defined as the capacities required to effectively manage grant funds, including a) adequate internal controls; b) an accounting system that accurately records all financial transactions and ensures that these transactions are supported by invoices, timesheets, and other documentation; c) adequate processes to control grant funds, d) evidence of receiving audits as appropriate, e) evidence of adequate administrative systems to facilitate procurement processes, filing of documentation, and appropriately allocated personnel.		
By improvement in subgrant management capacity			
	OVC care is defined as providing one or more of the following services and support to children, families, and their communities to ensure that orphans and vulnerable children grow and develop as valued members of their communities: psychological, spiritual, preventive, food support, shelter, protection, access to health care, education/vocational training, and economic strengthening.		
	Prevention programming is defined as the process of a) developing a solid analysis of the problem, b) conducting formative research with the target audience to understand the problem and potential barriers to behavior change, c) knowing about other interventions in the target area, d) determining the objectives of the project, e) determining the appropriate medium for messages, f) determining the appropriate language for the messages, g) validating the selected medium and messages, and h) evaluating the impact of the prevention program.		
	Reporting is required of grant recipients each quarter. The content of the reports are assessed on the accuracy of reporting on grant targets, the analysis that complements these targets, and information on how the organization will feed the M&E data into program implementation.		
	Subgrant management is defined as the process of soliciting, selecting, awarding, managing, and monitoring subgrants.		
Number of meetings facilitated to share experiences and lessons learned with CBOs/FBOs/NGOs	Meetings are defined as formally scheduled quarterly meetings for grant recipients, Intercambios, exchange visits, and other training events as well as less formal gatherings and events where CBOs/FBOs/NGOs share experiences and lessons learned with each other.	a) Project Records b) FHI 360 c) Semi-annually	Y1: 9 Y2: 9 Y3: 7 Y4: 11 Y5: 2 Baseline Value: 0
Number of indicators assessed by a data quality audit	CAP Mozambique conducts data verification exercises with its grant recipients at least once during the life of each grant award. During this data quality audit, data is tracked from the source document through to the final output (report to USAID) to identify potential gaps in the data collection/reporting process. Since the primary focus of these data quality audits is on the chain of data from source to USAID, priority is placed on verifying the data linked to PEPFAR and CAP indicators required by the CAP Mozambique project. 'Indicators' assessed would be defined as PEPFAR and/or CAP indicators included in this PMP that are included in one or more data	a) Project Records b) FHI 360 c) Semi-annually	Y1: N/A Y2: N/A Y3: N/A Y4: 4 Y5: 4

			Baseline Value: 0
quality audits conducted by the CAP team of its grant recipients.			

Result 2: Expanded HIV/AIDS prevention behaviors among most-at-risk groups through NGOs and partners programs

Performance Indicator	Indicator Definition	Data Collection a) Method, b) Responsibility, c) Frequency	Baseline/Target Values
Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards By MARP Type: CSW, clients of CSWs, IDU, MSM, Bridge and Mobile populations and their families (i.e. long-haul truck drivers), Miners and their families, Prisoners, Other Vulnerable Populations	Number of individuals in the intended population who are reached with individual- and/or small group- level interventions that are based on evidence and/or meet the minimum standards required. Individual-level interventions (ILI): Interventions that are provided to one individual at a time (e.g., individual counseling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Small group- level interventions (GLI): Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Evidence-based interventions: The most appropriate mix of programs and messages will depend on the country's epidemic, behavioral, and/or social science, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 618 Y2: 1,017 Y3: 0 Y4: 360 Y5: 660 Baseline Value: 0

By Sex: Male and Female	based on evidence and/or meet the minimum standards required.		
	Evidence-based interventions are those HIV behavioral interventions that have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination or reduction of risky sexual or drug- taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting the specific target population.		
	Minimum Standards Required: In the absence of evidence-based interventions, other interventions that could be considered for implementation are those that meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on a past successful program. All programs should use process-monitoring data to continually gauge the appropriateness of the intervention and plan to collect outcome-monitoring data to determine effectiveness.		
	In order to count persons reached, the interventions must: – have a clearly defined target population; – have clearly defined goals and objectives; – be based on sound behavioral and social science theory; – be focused on reducing specific risk behaviors – have activities that address the targeted risk behaviors – employ instructionally sound teaching methods – provide opportunities' to practice relevant risk reduction skills		
	Intended number of sessions: Number of sessions based on program description and as prescribed in the intervention. One component of fidelity in curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum- based sessions.		
	Core Package of Services for MARPS: Based on the epidemiologic profile for each country the aim of the country team should be to scale-up a combination of targeted interventions adapted for different sub-groups especially vulnerable to HIV. These interventions could include but are not limited to:		
	• Community-based peer outreach • Voluntary testing and counseling (specified in Care, Table 3.3.9) • Behavior change programs including targeted condom distribution for those who practice high-risk sexual behavior • Diagnosis and treatment of STIs • Referrals to a range of substance abuse and treatment services • Linkages through referral networks with other health services • Programs to prevent alcohol/drug- related sexual risk-taking behaviors and HIV transmission • Vocational skills training or other income-generation activities • Drop-in centers for creation of "safe space"		
	Service models (e.g. VCT) developed for a general population may need to be adapted to reach, engage, and meet the needs of most-at-risk populations. The country team is encouraged to incorporate tailored or innovative approaches that are likely to increase access and remove barriers to services for these populations. Use of qualitative methods to guide these adaptations has proven to be an effective strategy. The network model encourages and supports linkages to care and treatment as well. Keeping linkages in mind as care and treatment programs are planned will help achieve the overall PEPFAR goals and assist MARP populations.		

	Commercial Sex Workers (CSW): Effective CSW prevention programming should: 1. Ensure participation of target group in the development, implementation, and monitoring of prevention programs; 2. Promote consistent and proper use of condoms to achieve >90% use with both clients and regular non-paying partners/boyfriends/husbands; 3. Ensure consistent availability of quality male and female condoms and lubricant 4. Ensure availability of comprehensive health care services with special emphasis to quality VCT, STI and FP services and provision of or linkages to HIV treatment and care services 5. Integrate violence reduction (both social and structural) in prostitution settings 6. Link with relevant social welfare services for the target group and their families 7. Provide vocational training **Men Who Have Sex With Men (MSM):** Effective MSM prevention programming should: 1. Ensure participation of MSM in the development, implementation, and monitoring of prevention programs 2. Promote consistent and proper use of condoms to achieve >90% use with both regular and non-regular partners; 3. Ensure consistent availability of quality male and female condoms and lubricant 4. Ensure availability of comprehensive health care services with special emphasis to quality VCT and STI services and provision of or linkages to HIV treatment and care services. **Injection Drug Users:** Generally speaking, PEPFAR promotes three approaches to HIV prevention for substance abusers: 1. Tailoring HIV prevention programs to substance abusers: these programs should rely on tools, guidelines, and evidence-based interventions designed to reduce risk of HIV transmission. A comprehensive program should include: information and education community based outreach risk reduction counseling; targeted condom distribution activities and substance abuse treatment, and to address HIV prevention and risk reduction. These services should be provided in multiple venues to reach this hard to reach population and engage them in activities to enable them to eliminate/reduce risks for acquiring and/or transmitting HIV. 2. Offering HIV-infected drug users a comprehensive program to reduce their risk of transmission: a comprehensive multi-component HIV/AIDS treatment program for substance abusers should promote recovery through confidential HIV counseling and testing, ART, palliative care, STI and tuberculosis treatment, substance abuse treatment (including medication-assisted therapies) and transitional services between treatment facilities and the community. 3. Supporting substance abuse programs as an HIV prevention measure: these programs may include behavioral models or medication-assisted treatment (e.g. using methadone or buprenorphine), or a combination of the two, and should also include case management and counseling services. Medication-assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services.		
Number of community health and para-social workers who successfully completed a pre-	The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or	a) Project Records	Y1: 295 Y2: 15

service training program	national standards. "Pre-service" training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a 'refresher' course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator.	b) FHI 360 c) Annually	Y3: 0 Y4: 15 Y5: 0 Baseline Value: 0
Cadre: APE; Community Health Activists; Para-social workers By Sex: Male, Female			

Pre-service training programs must be nationally accredited, or at the minimum meet national standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria mentioned here. For the purposes of this indicator, health and social workers include the following:

1. Community health workers, which in Mozambique are referred to as Agentes Polivalentes Elementares (APEs), whose functions and training are outlined in the nationally approved APE operational plan. The objective of APEs is to contribute to improving health in their communities through health promotion/ disease prevention activities, some curative activities (e.g. treatment of uncomplicated cases of malaria, diarrhea, respiratory infections, first aid), and serving as the link between the community and the public health sector. These individuals will be counted upon successfully finishing the APE training course.

2. Community health activists (Agentes Comunitarios de Saude, ACSs), also called "activistas," are trained for few days or weeks and supervised by health professionals in conjunction with NGOs or partners. These activists provide basic nursing care or health specific tasks that include preventive medicine, distribution of oral rehydration salts, condoms, etc. These activists include home-based care activists, traditional birth attendants, Child Health activists, TB activists, leprosy activists, etc.

3. Para-social workers [quadros elementares de acção social] work at the community level and are trained in social work skills, with less than 6 months' training. They provide health and social support services to meet the physical and social needs of vulnerable people, including OVC. They are the liaison between beneficiaries/vulnerable individuals and health and social support services. An illustrative, but not exhaustive, list of para-social workers include: home visitors, caregivers, peer educators, adherence counselors, lay counselors, etc. There is no need to disaggregate paid/unpaid workers. "Para-social" workers often work under the supervision of a professional social worker, nurse, or physician; this is a descriptor only for 'para-social' worker and not a condition/criterion in order to count for this indicator.

Number of individuals trained in institutional capacity building	Institutional capacity building is defined as training that supports an organization's capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills.	a) Project Records b) FHI 360 c) Quarterly and Annually	Y1: 63 Y2: 78 Y3: 40 Y4: 48 Y5: 3 Baseline Value: 0
By individuals trained to promote HIV/AIDS prevention through behavior change	Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.		

Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or "hands-on" training, such as mentoring or structured supervision, if the following three criteria are met:

   1) Training objectives are clearly defined and documented;
   2) Participation in training is documented (e.g. sign-in sheets or some other type of auditable training); and
   3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.)

	Training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.		
Number of targeted condom service outlets	This indicator refers to a fixed distribution point or a mobile unit with a fixed schedule that provides condoms for free or for sale to a given community as an important part of a comprehensive HIV prevention message. The numerator can be generated by summing the number of condom service outlets with fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale. Community distribution outlets that include condoms can also be included. Condom outlets should be counted so long as USG support is provided in a way that enables or increases the availability of condoms, even if the program is not funded as an activity under condoms and other prevention. For example, if USG is directly supporting a counseling and testing site that also provides condoms, this can be counted as a USG-supported condom service outlet so long as USG support is contributing to the increased availability of condoms at the site. Condom outlets should only be counted at the end distribution point, such as a health facility, a community venue, etc. This does not include supply chain distribution or distribution at the provincial or district level. Condom outlets should be counted where a unique program is being implemented and/or a unique population served. If a facility has multiple places where condoms are available but each of these places serve essentially the same population (multiple stalls in a bathroom), this location can only be counted once. If USG support contributes to the increased availability of condoms within multiple places or programs within one facility (e.g. Within the counseling and testing program, antenatal program, and TB clinic in one health facility), each of the different locations where a different population is being served can be counted as a unique condom service outlet.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 4 Y2: 30 Y3: 4 Y4: 125 Y5: 125 Baseline Value: 0
Number of mass media spots delivered	Mass media is defined as the dissemination of prevention messages through media specifically envisioned and designed to reach a very large audience, such as the national, provincial, or district population, or specific target populations (e.g. Women, youth, high risk groups.) Mass media typically includes radio networks, mass-circulation newspapers and magazines, television, and digital media. There is typically little focus on interpersonal interaction in mass-media and community mobilization messages/programs. The indicator can be generated by summing the number of mass media spots for each category for the reporting period. This indicator measure the number of media spots delivered, not the number of persons reached through the indicator. Each time a media sport is delivered/presented should be counted as one number regardless of the size of the audience receiving message. For print publications, depending on the time of media being used should be counted as the number of times an public service advertisement is run in a local newspaper or journal. The flyers of leaflets, the number should reflect the number of times that the print document was distributed en masse for public consumption.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 6 Y2: 50 Y3: 0 Y4: 30 Y5: 30 Baseline Value: 0
Increased number of individuals who have sought counseling and testing	Individuals are counted if they have attempted to seek counseling and testing regarding their HIV/AIDS status.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: IDU: 64% CSW: 80%
By Sex: Male and Female			
By MARP Type: CSW, IDU, MSM, Other Vulnerable Populations			

Percentage of individuals reporting increased dialogue about high-risk behaviors	Dialogue about high-risk behaviors includes any conversations between individuals or within small groups about high-risk behaviors for HIV/AIDS. High-risk behaviors include: engaging in sexual activity with multiple partners, sharing needles, and engaging in unprotected sex.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: With partner/spouse: No dialogue: IDU - 22%, CSW – 24% With family/friend: No dialogue: IDU – 16%, CSW – 20% With peer educator: No dialogue: IDU – 49%, CSW – 46%
By Sex: Male and Female			
By MARP Type: CSW, IDU, MSM, Other Vulnerable Populations			
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 2. Can a person reduce the risk of getting HIV by using a condom every time they have sex? 3. Can a healthy-looking person have HIV? 4. Can a person get HIV from mosquito bites? 5. Can a person get HIV by sharing food with someone who is infected? The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: "Can a person get HIV by hugging or shaking hands with a person who is infected?" and "Can a person get HIV through supernatural means?" Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of "don't know" should be recorded as an incorrect answer. The indicator should be presented as separate percentages for males and females and should be disaggregated by the age groups 15-19 and 20–24 years. Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: IDU: Male 15-19 yrs: 64% Female 15-19 yrs: 0% Male 20-24 yrs: 40% Female 20-24 yrs: 20% CSW: Male 15-19 yrs: 50% Female 15-19 yrs:33% Male 20-24 yrs: 43% Female 20-24 yrs: 44%
By Sex: Male and Female			
By MARP Type: CSW, IDU, MSM, Other Vulnerable Populations			
By Age: 15-19, 20-24			
Increased number of individuals reporting consistent use of condoms	The reporting of correct condom use is determined by affirming that the user: a) checked the expiration date of the condoms, b) understood the condom use instructions, c) used the condom on an erect penis, d) pinched the tip of the condom and unrolled it slowly over the erect penis up to the base, and e) following intercourse held the base of the condom and rolled it off the erect penis for disposal. Consistent condom use is defined by asking whether condoms were used in the most recent sex act, as this generally reflects the trend toward consistent condom use.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: IDU: 70%
By Sex: Male and Female			
By MARP Type: CSW, IDU, MSM, Other Vulnerable Populations			

				CSW: 96%

Result 3: Increased numbers of youth, young adults, and adults in sexual relationships avoiding high-risk behaviors that make them vulnerable to HIV/AIDS infections

Performance Indicator	Indicator Definition	Data Collection a) Method, b) Responsibility, c) Frequency	Baseline/Target Values
Number of intended target population reached with individual and/or small group level interventions that based on evidence and/or meet the minimum standards By Sex: Male, Female By Age: 10-11 years old; 12-14 years old; 15-24 years old/ 25+ years old By OVC	Number reached: Number of individuals in the intended target population who are reached with individual- and/or small group level interventions that are based on evidence and/or meet the minimum standards required. Intended Target Population: The specific target population around which a prevention intervention was intentionally designed. Populations to be counted in this indicator are general population adult and/or youth, including both in school and out of school youth. For this indicator, populations that participate in a variety of behavioral risks could be counted, including but not limited to the following illustrative examples: individuals who engage in: transactional sex, (giving or receiving a gift in exchange for sex); sex under the influence of alcohol; other behaviors that could place them at risk of transmission. Only individuals representing the specific 'intended audience' will count under this indicator. For example: If a program activity is designed to target youth (ages 10-15) and individuals who are much older or much younger than the intended target population participate in the activity, then these individuals should not be counted. Only the 10-15 year olds for which the program was designed should be counted. • Another significant clarification made to the 'Method of Measurement' section: o Language added: In order to be counted, an individual should complete the intended number of sessions that were implemented with fidelity to the intervention. Individual-level interventions (ILI): Interventions that are provided to one individual at a time (e.g., individual counseling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Small group level interventions (GLI): Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Evidence-based interventions: The most appropriate mix of programs and messages will depend on the country's epidemic, behavioral, and/or social science, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. HIV behavioral interventions that have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination or reduction of risky sexual or drug taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting the specific target population. Minimum Standards Required: In the absence of evidence-based interventions, other interventions that could be considered for implementation are those who meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on a past successful program. All programs should use process monitoring data to continually gage the appropriateness of the intervention and plan to collect outcome monitoring data to determine effectiveness. In order to count persons reached, the interventions must:	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 20,470 Y2: 23,274 Y3: 11,606 Y4: 40,516 Y5: 43,819 Baseline Value: 0

	– have a clearly defined audience – have clearly defined goals and objectives – be based on sound behavioral and social science theory – be focused on reducing specific risk behaviors – have activities that address the targeted risk behaviors – employ instructionally sound teaching methods – provide opportunities' to practice relevant risk reduction skills Intended number of sessions: Number of sessions based on program description and as prescribed in the intervention. One component of fidelity in curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum based sessions. Comprehensive Prevention Programs: Implementing a comprehensive prevention program at the country level involves multiple components such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff. Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, and individual) as well as providing a range of messages that are appropriate for the country's epidemic and the specific target group. Prevention programs should appropriately link to services such as male circumcision and counseling and testing, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal. The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country's epidemic, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. This indicator only counts those interventions at the individual and/or small group level. Individual- and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.		
Number of intended target population reached with individual- and/or small group- level interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards By Sex: Male, Female By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old By OVC	Primarily focused: The messages and content of the activities spend the majority of their time discussing; increasing individual and group's self-risk assessments; building the skills; and other supportive behavioral, cognitive and social components to increase the AB behaviors. Abstinence and/or being faithful: AB interventions can include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills-based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills. Comprehensive Prevention Programs: Implementing a comprehensive prevention program at the country level involves multiple components, such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 28,473 Y2: 32,744 Y3: 3,426 Y4: 8,500 Y5: 8,995 Baseline Value: 0

		Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, individual) as well as providing a range of messages that are appropriate for the country's epidemic and the specific target group. Prevention programs should appropriately link to services, such as male circumcision and counseling and testing, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal. The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country's epidemic, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. This indicator only counts those interventions at the individual- and/or small-group level. Individual- and small group-level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.		
Number of community health and para-social workers who successfully completed a pre-service training program Cadre: APE; Community Health Activists; Para-social workers	The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. "Pre-service" training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a 'refresher' course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator. Pre-service training programs must be nationally accredited, or at the minimum meet national standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria mentioned here. For the purposes of this indicator, health and social workers include the following: 1. Community health workers, which in Mozambique are referred to as Agentes Polivalentes Elementares (APEs), whose functions and training are outlined in the nationally approved APE operational plan. The objective of APEs is to contribute to improving health in their communities through health promotion/ disease prevention activities, some curative activities (e.g. treatment of uncomplicated cases of malaria, diarrhea, respiratory infections, first aid), and serving as the link between the community and the public health sector. These individuals will counted upon successfully finishing the APE training course. 2. Community health activists (Agentes Comunitarios de Saude, ACSs), also called "activistas,", are trained for few days or weeks and supervised by health professionals in conjunction with NGOs or partners. These activists provide basic nursing care or health specific tasks that include preventive medicine, distribution of oral rehydration salts, condoms, etc. These activists include home-based care activists, traditional birth attendants, Child Health activists, TB activists, leprosy activists, etc. 3. Para-social workers [quadros elementares de acção social] work at the community level and are trained in social work skills, with less than 6 months' training. They provide health and social support services to meet the physical and social needs of vulnerable people, including OVC. They are the liaison between beneficiaries/vulnerable individuals and health and social support services. An illustrative, but not exhaustive, list of para-social workers include: home visitors, caregivers, peer educators, adherence counselors, lay counselors, etc. There is no need to	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 323 Y2: 242 Y3: 420 Y4: 1,604 Y5: 1,054 Baseline Value: 0

	disaggregate paid/unpaid workers. "Para-social" workers often work under the supervision of a professional social worker, nurse, or physician; this is a descriptor only for 'para-social' worker and not a condition/criterion in order to count for this indicator.		
Number of people referred to health services by community-based organizations	Community based organization is defined as any civil society organization that works in the community.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: N/A Y2: N/A Y3: N/A Y4: TBD Y5: TBD Baseline Value: 0

Number of individuals trained in institutional capacity building
 	
By individuals trained to promote HIV/AIDS prevention through behavior change
	Institutional capacity building is defined as training that supports an organization's capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills.
	
	Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills, or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.
	
	Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training
	
	as well as on the job or "hands-on" training, such as mentoring or structured supervision if the following three criteria are met:
	
	  1) Training objectives are clearly defined and documented;
	  2) Participation in training is documented (e.g. sign-in sheets or some other type of auditable training); and
	  3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.).
	
	Training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.
			Y1: 63
			Y2: 78
			Y3: 40
			Y4: 48
			Y5: 3
			
			Baseline Value: 0

Increased number of individuals reporting reduction of engagement risk behaviors associated with HIV By Sex: Male, Female By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old	Risk behaviors include: engaging in sexual activity with multiple partners, sharing needles, and engaging in unprotected sex. Individuals are counted when they report a reduction in frequency of engaging in these behaviors.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: Multiple Partners: Female 15-24: 28% Female 25+: 18% Male 15-24: 44% Males 25+: 42% Sharing Needles:

			Always share: Females 25+: 39% Males 25+: 8% Never share: Female 15-24 yrs: 66% Female 25+: 29% Male 15-24 yrs: 0% Male 25+: 39% Unprotected sex: Female 15-24 yrs: 85% Female 25+: 92% Male 15-24 yrs: 69% Male 25+: 84% No condom at last sex: Female: 15-19 yrs: 81% Female 20-24 yrs: 83% Female 25+ yrs: 92% Male 15-19 yrs: 63% Male 20-24 yrs: 75% Male 25+ yrs: 82%
Increased number of individuals who have sought counseling and testing By Sex: Male and Female	Individuals are counted if they have attempted to seek counseling and testing regarding their HIV/AIDS status.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: Females: 35% Males: 28%

Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
 	
    By Sex: Male and Female
    By Age: 15-19, 20-24
	This indicator is constructed from responses to the following set of prompted questions:
	
	1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
	2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
	3. Can a healthy-looking person have HIV?
	4. Can a person get HIV from mosquito bites?
	5. Can a person get HIV by sharing food with someone who is infected?
	
	The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be
		a) Baseline Survey
		
		b) FHI 360
		
		c) Mid-term, Final
			Y1: 0
			Y2: 0
			Y3: 0
			Y4: 0
			Y5: TBD
			
			Baseline Value:
			
			Female 15-19: 44%

			Female 20-24: 47% Male 15-19: 52% Male 20-24: 40%
Percentage of individuals reporting increased dialogue about high-risk behaviors By Sex: Male and Female	Dialogue about high-risk behaviors includes any conversations between individuals or within small groups about high-risk behaviors for HIV/AIDS. High-risk behaviors include: engaging in sexual activity with multiple partners, sharing needles, engaging in unprotected sex.	a) Baseline Survey b) FHI 360 c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: With partner/spouse: No dialogue: Male – 18%, Female – 23% With family/friend: No dialogue: Male – 18%, Female – 22% With peer educator: No dialogue: Male – 35%, Female – 38%
Percentage of individuals reporting increased dialogue about social norms that influence high-risk behaviors By Sex: Male and Female By Age: 10-11 years old; 12-14 years old; 15-24 years old; 25+ years old	Dialogue about high-risk behaviors includes any conversations between individuals or within small groups about high-risk behaviors for HIV/AIDS. Social norms are defined as individual or group perceptions, opinions, or norms. These can include perspectives about men and women roles, perceptions that it is acceptable for teachers to have sex with their students, perceptions about local youth initiation rites, and others.	a) Baseline Survey b) FHI 360, Grantees c) Mid-term, Final	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: With partner/spouse: No dialogue: Male – 29%, Female – 44% With family/friend: No dialogue: Male – 27%, Female – 38% With peer educator: No dialogue: Male – 45%, Female – 47%

Result 4: Increased numbers of orphans and vulnerable children (OVC) receiving quality, comprehensive care in their respective target areas			
Performance Indicator	**Indicator Definition**	**Data Collection a) Method, b) Responsibility, c) Frequency**	**Baseline/Target Values**
Number of OVC receiving OVC services By Sex: Male; Female By Type of service: Economic Strengthening By Type of service: Food and Nutrition By Type of service: Shelter and Care By Type of service: Education and/or vocational training By Type of service: Health care By Type of service: Psychosocial, social, and/or spiritual support By Type of service: Protection	The Number of OVCs receiving services should is a unique number where each client is counted only once. The disaggregation by service indicator will count all OVCs receiving services by that service area. If an OVC received multiple services than they should be counted multiple times for the service areas and one time for the indicator. PEPFAR CARE programs include both support and clinical services. Clinical Services – Include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services may be provided in facilities, the community, or in the home, and may include both assessment of the need for interventions (for example assessing pain, clinical staging, eligibility for cotrimoxazole, or screening for tuberculosis) or provision of needed interventions. These services are further defined under the CARE indicator for Clinical Services for HIV-positive. Support Services – Include a broad range of services, which provide social, psychological, or spiritual support and are appropriate for all persons who are affected by HIV, including people living with HIV/AIDS (PLWHA). Support services fall into these broad categories: Psychological, spiritual, preventive, food support*, shelter, protection, access to health care, education/vocational training, and economic strengthening. To count under this indicator, OVCs must receive a minimum of one care service. OVCs need to receive only one care service to count; however, PEPFAR programs should seek to provide a comprehensive set of support and clinical services, appropriately tailored to the status of the individual or family. This comprehensive set of services should include linkages to partners providing other types of services as indicated. For HIV-infected persons, programs should ensure that patients receive services through the full continuum of care, which extends specifically to clinical services (see indicator C2.1D) and eventually to anti-retroviral therapy (CCC9).	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1:1520 Y2:1474 Y3: 1,200 Y4: 4,050 Y5: 5,730 Baseline Value: 0

Number of community health and para-social workers who successfully completed a pre-service training program	The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. "Pre-service" training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a 'refresher' course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator. Pre-service training programs must be nationally accredited, or at the minimum meet national standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria mentioned here. For the purposes of this indicator, health and social workers include the following: 1. Community health workers, which in Mozambique are referred to as Agentes Polivalentes Elementares (APEs), whose functions and training are outlined in the nationally approved APE operational plan. The objective of APEs is to contribute to improving health in their communities through health promotion/ disease prevention activities, some curative activities (e.g. treatment of uncomplicated cases of malaria, diarrhea, respiratory infections, first aid), and serving as the link between the community and the public health sector. These individuals will counted upon successfully finishing the APE training course.	a) Project Records b) FHI 360, Grantees Quarterly and Annually	Y1: 306 Y2: 80 Y3: 173 Y4: 287 Y5: 287 Baseline Value: 0
Cadre: APE; Community Health Activists; Para-social workers			
By Sex: Male; Female	2. Community health activists (Agentes Comunitarios de Saude, ACSs), also called "activistas,", are trained for few days or weeks and supervised by health professionals in conjunction with NGOs or partners. These activists provide basic nursing care or health specific tasks that include preventive medicine, distribution of oral rehydration salts, condoms, etc. These activists include home-based care activists, traditional birth attendants, Child Health activists, TB activists, leprosy activists, etc. 4. Para-social workers [quadros elementares de acção social] work at the community level and are trained in social work skills, with less than 6 months' training. They provide health and social support services to meet the physical and social needs of vulnerable people, including OVC. They are the liaison between beneficiaries/vulnerable individuals and health and social support services. An illustrative, but not exhaustive, list of para-social workers include: home visitors, caregivers, peer educators, adherence counselors, lay counselors, etc. There is no need to disaggregate paid/unpaid workers. "Para-social" workers often work under the supervision of a professional social worker, nurse, or physician; this is a descriptor only for 'para-social' worker and not a condition/criterion in order to count for this indicator.		
Number of individuals trained in institutional capacity building	Institutional capacity building is defined as training that supports an organization's capacity to respond to the HIV/AIDS epidemic. This includes organizational development as well as HIV/AIDS technical skills. OVC	a) Project Records	Y1: 72

Performance Indicator	Indicator Definition	Data Collection a) Method, b) Responsibility, c) Frequency	Baseline/Target Values
By OVC care	care is the provision of one or more of the following services and support to children, families, and their communities to ensure that OVC grow and develop as valued members of their communities: psychological, spiritual, preventative, food support, shelter, protection, access to health care, education/vocational training, and economic strengthening. Training is a learning activity taking place in-country, in a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently. Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or "hands-on" training, such as mentoring or structured supervision, if the following three criteria are met: 1) Training objectives are clearly defined and documented; 2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training); and 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.). Training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. Training may update existing knowledge and skills, or add new ones.	b) FHI 360, Grantees c) Quarterly and Annually	Y2: 74 Y3: 10 Y4: 29 Y5: 18 Baseline Value: 0
Number of people referred to health services by community-based organizations	Community based organization is defined as any civil society organization that works in the community.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: N/A Y2: N/A Y3: N/A Y4: TBD Y5: TBD Baseline Value: 0

Result 5: Increased quality and coverage of home-based health care (HBC) to people living with AIDS (PLWHA) and their families .

Performance Indicator	Indicator Definition	Data Collection a) Method, b) Responsibility, c) Frequency	Baseline/Target Values
Number of clients receiving home-based care services Type of Outcome: Alive and still in HBC; Lost-to-follow-up; Death; Discharged Sex: Male; Female	The Number of clients receiving home based care services should count each unique client only once for the reporting period. Only support services should be included for this indicator. Any client who received home based care services at any point during the reporting period should be counted, regardless of their status at the end of the period (i.e. they do not have to be actively receiving home based care services—due to death, loss to follow up, discharge, etc.—at the end of the period in order to count). Support Services – Include a broad range of home-based care services for all persons living with HIV/AIDS	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 0 Y2: 0 Y3: 0 Y4: 36 Y5: 36 Baseline Value: 0

Age: 0-14 years; 15+ years	(PLWHA). All home-based activities for HIV-infected adults and children aimed at optimizing quality of life for HIV-infected (diagnosed or presumed) clients throughout the continuum of illness, by means of: symptom diagnosis and relief; psychological and spiritual support; clinical monitoring, related laboratory services, and management (and/or referral for these) of opportunistic infections including TB, malaria, and other HIV/AIDS-related complications (including pharmaceuticals); culturally-appropriate end-of-life care; social and material support such as nutrition support, legal aid, and housing; and training and support for caregivers. Definitions for types of outcomes: Alive and on ART – Clients who are believed by the program team to be still alive and considered as actively receiving HBC services as of the end of the reporting period. Lost-to-follow-up – Clients who have discontinued home based care for unknown reasons. Partner reporting systems should have a system in place for capturing lost-to-follow-up clients. Clients should be confirmed as lost-to-follow-up after three continuous attempts to contact the client. Confirmation of client lost to follow up can also be acquired through verbal confirmation. Death – Confirmed status by the home based care provider regarding the death of a client from point of service. Discharged – Home Based Care clients that have been officially discharged from home based care by the home based care provider based on the psychosocial, emotional, and physical health of the client.		
Number of community health and para-social workers who successfully completed a pre-service training program Cadre: APE; Community Health Activists; Para-social workers By Sex: Male; Female	The number is the sum of community health and social workers who successfully completed a pre-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. "Pre-service" training comprises training that equips community health and social workers (CHSWs) to provide services for the first time. Oftentimes, CHSWs are given pre-service training once they have been hired but before they begin providing services to the community – these individuals would count towards this indicator. Individuals that receive a 'refresher' course that also includes an agenda, curriculum, participant list, and criteria for counting successful completion of the course also will be counted for this indicator. Pre-service training programs must be nationally accredited, or at the minimum meet national standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria mentioned here. For the purposes of this indicator, health and social workers include the following: 1. Community health workers, which in Mozambique are referred to as Agentes Polivalentes Elementares (APEs), whose functions and training are outlined in the nationally approved APE operational plan. The objective of APEs is to contribute to improving health in their communities through health promotion/ disease prevention activities, some curative activities (e.g. treatment of uncomplicated cases of malaria, diarrhea, respiratory infections, first aid), and serving as the link between the community and the public health sector. These individuals will be counted upon successfully finishing the APE training course. 2. Community health activists (Agentes Comunitarios de Saude, ACSs), also called "activistas," are trained for few days or weeks and supervised by health professionals in conjunction with NGOs or partners. These	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: 81 Y2: 93 Y3: 115 Y4: 96 Y5: 0 Baseline Value: 0

| | | activists provide basic nursing care or health specific tasks that include preventive medicine, distribution of oral rehydration salts, condoms, etc. These activists include home-based care activists, traditional birth attendants, Child Health activists, TB activists, leprosy activists, etc.

3. Para-social workers [quadros elementares de acção social] work at the community level and are trained in social work skills, with less than 6 months' training. They provide health and social support services to meet the physical and social needs of vulnerable people, including OVC. They are the liaison between beneficiaries/vulnerable individuals and health and social support services. An illustrative, but not exhaustive, list of para-social workers include: home visitors, caregivers, peer educators, adherence counselors, lay counselors, etc. There is no need to disaggregate paid/unpaid workers. "Para-social" workers often work under the supervision of a professional social worker, nurse, or physician; this is a descriptor only for 'para-social' worker and not a condition/criterion in order to count for this indicator. | | |

Additional USAID Health Indicators			
Performance Indicator	**Indicator Definition**	**Data Collection** **a) Method,** **b) Responsibility,** **c) Frequency**	**Baseline/Target Values**
Increased male involvement in seeking health services	In the context of the CAP Mozambique project, increased male involvement refers to any increase in men seeking counseling and testing, and increases in men supporting their female partners in seeking counseling and testing.	a) Baseline Survey b) FHI 360 c) End of Project	Y1: 0 Y2: 0 Y3: 0 Y4: 0 Y5: TBD Baseline Value: Never: 71% HCT with Partner: 36% No HCT with partner: 62%

Number of individuals reached through USG-funded community health activities	Individuals reached through USG-funded community health activities include all individuals reached through CAP Mozambique prevention and OVC activities implemented through CSO partners.	a) Project Records b) FHI 360 c) Quarterly	Y1: 51,081 Y2: 58,509 Y3: 16,232 Y4: 53,462 Y5: 58,880 Baseline Value: 0

PEPFAR Gender Indicators:				
Performance Indicator	**Indicator Definition**	**Data Collection a) Method, b) Responsibility, c) Frequency**	**Baseline/Target Values**	
Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion (GBV)	The result can be generated by counting the number of adults and children who were reached by an individual, small group or community-level intervention or service that explicitly addressed GBV during the reporting period. These interventions or services are cross-cutting and contribute to results across a range of PEPFAR program areas. Individuals reached by mass media interventions are not counted in this indicator. Individuals counted under this indicator may also be captured under other relevant prevention indicators.	a) Project Records b) FHI 360 c) Quarterly	Y1: N/A Y2: N/A Y3: N/A Y4: 4,052 Y5: 6,079 Baseline Value: 0	
By Sex; Male, Female	**Number of adults and children reached** is the number of individuals who are provided with the intended intervention as defined in the program description and as prescribed in the intervention or service.			
By Age: 0-4, 5-9, 10-14, 15-17, 18-24 and 25+	**Individual-level interventions** or services are those that explicitly address GBV and are provided to one individual at a time, e.g. job skills training, tuition grants, etc.			
By District	**Small-group-level interventions** or services are those that explicitly address GBV and are delivered in small group settings (less than 25 people), e.g. empowerment training for women in microfinance projects, men's support groups addressing gender norms, information dissemination to women's groups, etc. **Community-level interventions** or services that explicitly address GBV and are delivered in community-wide settings (25 or greater people), e.g., awareness raising forums, town hall meetings, large discussion groups, etc. To be able to count individuals reached for this indicator, individual, small group, or community-level interventions must address the following topics: • Definition of Gender Based Violence • Description/Discussion of types of Gender Based Violence that exist • Information on where to seek support for GBV cases • Link between HIV&AIDS and GBV • Provide information about GBV legislation			

Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.	The numerator can be generated bv counting the number of adults and children who were reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS during the reporting period. Individuals reached by mass media interventions or services are not counted in this indicator. Definitions: Norms about masculinity related to HIV/AIDS include those that govern the following behaviors: cross generational and transactional sex, multiple concurrent partnerships, alcohol/substance misuse/abuse, inequitable control of household resources, poor use of health care services, lack of support for partner´s health care concerns, and limited involvement in HIV/AIDS care-giving. Interventions or services that explicitly address norms about masculinity related to HIV/AIDS seek to change traditional, cultural, and social male norms that contribute to behaviors that increase HIV/AIDS risk in both men and women, and that impede access to care and treatment services for those who need them. These interventions are cross-cutting and contribute to results across a range of PEPFAR program areas, including prevention, care, and treatment. **Number of adults and children reached** is the number of individuals who are provided with the intended intervention as defined in the program description and as prescribed in the intervention or service. **Individual-level interventions** or services are provided to one individual at a time, e.g individual counseling, mentoring, etc. **Small-group-level interventions** or services are those delivered in small group settings (less than 25 people, e.g. workplace programs, men´s support groups, etc.), **Community-level interventions** or services that explicitly address GBV and are delivered in community-wide settings (25 or greater people), e.g.town hall meetings, community-wide education campaigns, etc. CAP is still in the process of defining the criteria to enable organizations to count individuals as reached under this indicator.	a) Project Records b) FHI 360, Grantees c) Quarterly and Annually	Y1: N/A Y2: N/A Y3: N/A Y4: TBD Y5: TBD Baseline Value: 0
By Sex; Male, Female			
By Age: 0-15, 15-24, 25+			
By District			